Riley County – Manhattan Health Department

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Riley County-Manhattan Health Department's Notice of Privacy Practices with the effective date of April 14, 2003.

| Signature of Patient/Patient Representative | Patient Date of Birth |
|---|-------------------------|
| Relationship to Patient | Printed Name of Patient |
| | Filined Name of Fatient |
| Date | |

Original to be maintained in Patient's permanent medical record.